South West **LHIN**

South West Local Health Integration Network
Annual Report 2013-2014

Ontario
Local Health Integration Network

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Message from Jeff Low, Board Chair and Michael Barrett, CEO

The 2013-14 fiscal year was a very busy and successful time for the South West LHIN. We continued to take an active role in leading and shaping the transformation of the health system through our decisions and investments. Supported by sound strategic analysis and continuing engagement, we were able to advance our goals by working closely with our provider partners and important stakeholders.

This was the first year we operated under the strategic directions of our new Integrated Health Service Plan 2013-16 (IHSP) and it will continue to guide us as we make decisions, large and small, to create a more integrated and sustainable health system. For the first time, we took the IHSP directly to provider boards and asked them to consider in more detail how they can align their own strategies with ours and we were gratified by the thoughtful comments and issues raised as we talked to board members across the South West LHIN.

The LHIN Board worked with our health service providers (HSPs) to make decisions on important targeted investments in 2013-14. The Board approved just over $20 million for the community sector to expand community health services across the LHIN. While the ministry allocated the funding to the LHINs specifically for use in the community sector, each LHIN determined how best to invest funds locally to address pressures and enhance services in our area. Overall, our allocation strategy was designed to fund HSPs to support people – largely seniors, those with high medical needs and those with mental health and addictions issues – to receive more care in the community and avoid unnecessary hospitalizations.

An example of this is the South West LHIN is supporting the development of Health Links in our area. A Health Link is designed to help close the gaps that often occur when a patient moves from one health care provider to another. Better coordinated care is an important step in improving the services available to patients with complex needs and frequent interactions with the health system. This coordination, under the umbrella of a Health Link and led by local HSPs, will mean they can stay healthier for longer and get the right treatment, at the right time, in the right place. The Huron Perth Health Link was the first to be approved and partners will begin working together to provided enhanced coordinated care to patients in 2014. The London-Middlesex Health Link was approved for operation late in March 2014 and four other Health Links are in the formative stages across the LHIN.

The board worked closely with staff and stakeholders to make several important decisions that directly impacted providers and communities across the LHIN. In November, the board made an important decision to approve changes to the number of complex continuing care and rehabilitation beds through a facilitated integration. This will see 10 new beds open in the north (Grey and Bruce counties) with a reduction of beds in Oxford County.

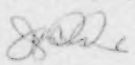
In October of 2013, we approved the amalgamation of three mental health and addictions agencies in the London Area. This will see better coordination of services and care for their clients and a broader range of programs to help them continue to seek care in the community instead of a hospital setting.

Another significant acknowledgment that the work we help enable adds real value to the system was the provincial roll out of the "Life or Limb No-Refusal" protocol. This protocal was designed to ensure that the sickest patients are transferred to the most appropriate facility to help them as fast as possible. Life or Limb was developed and implemented by hospitals in the South West LHIN in 2012, led by the London Health Sciences Centre and the South West LHIN's Critical Care Lead, Dr. Mike Sharpe. It was made a provincial policy by Critical Care Services Ontario and rolled out across Ontario in 2013-14.

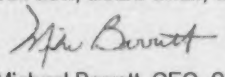
This summary is only a highlight of the many decisions and issues the South West LHIN has addressed in the past year. There are more details throughout this report

about the important work that has been completed and new projects that are underway.

At the South West LHIN, we continue to advance with "system level" issues such as accountability, health service provider performance and health system coordination. We remain grateful for the hard work that frontline clinical staff and physicians continue to provide to their patients, residents and clients every day. We also appreciate the dedication of the many staff, managers and directors who participate on our committees and project teams to ensure we have the necessary input to make the best decisions possible.



Jeff Low, Board Chair, South West LHIN



Michael Barrett, CEO, South West LHIN

Board of Directors

Board members as of March 31, 2014

Jeff Low (London), Chair
February 7, 2014 - February 6, 2017

Ron Bolton (St. Marys) Vice Chair
May 12, 2013 - May 11, 2016

Andrew Chunilall (London)
April 11, 2013 - April 10, 2016

Ron Lipsett (Annan)
July 28, 2013 - July 27, 2016

Gerry Moss (Port Elgin)
May 17, 2011 – December 31, 2015

Wil Riecker (Port Stanley)
November 6, 2013 - November 5, 2016

Lori Van Opstal
November 6, 2013 - November 5, 2016

Aniko Varpalotai (Elgin County)
October 3, 2012 - October 2, 2015

Barbara West-Bartley(Wiarton)
April 18, 2011 - April 17, 2014

Member whose term expired during 2013-14

Sheryl Feagan (Goderich), July 15, 2013

The South West LHIN

The South West LHIN was established in 2005 to plan, fund, and integrate health services in a mixed rural-urban geography that ranges from the tip of the Bruce Peninsula to the shores of Lake Erie. Our area includes a world renowned teaching hospital and mid-sized hospitals in cities such as Owen Sound, Stratford and Woodstock. We also have over two dozen hospital sites that serve the smaller towns and farm communities throughout our LHIN. Each has a role to play in partnership with community and long-term care providers to provide quality health care that can be sustained into the future.

A large part of the LHIN's role is to ensure optimal use of all health care resources, including those agencies that provide much needed community-based services. We have recently developed our third Integrated Health Service Plan (IHSP) which will guide our activities and initiatives for the next three years, and is focused on helping people *live healthy, independently and safely at home.*

Hospitals in the LHIN provide exceptional acute care for those who are very ill, and our long-term care homes are available for individuals whose care needs can no longer be accommodated in the community. However, for the vast majority of people who require support, health care needs can and should be met in their home community. Whether it is in-home care from a personal support worker, or an adult day program for individuals with dementia, community services are the key to the future sustainability of the health care system as they allow earlier discharge from hospitals, prevent re-admissions, and help delay or avoid admission to long-term care homes.

The South West LHIN population receives services from an array of LHIN and non-LHIN funded organizations across the community, long-term care and acute health sectors. Residents rely on these organizations for a variety of needs including home/social support, episodic, chronic and long-term care.

The following LHIN-funded organizations play a critical role in delivering services to its residents:

- 20 Hospital Corporations (32 sites)
- 79 Long-Term Care Homes
- 60 Community Support Service Agencies
- 36 Mental Health and Addiction Agencies
- 5 Community Health Centres
- 1 Community Care Access Centre

In addition, non-LHIN funded organizations, such as family health teams, family health organizations, family health networks, solo-physician offices, public health units, emergency medical services and labs play a critical role in the delivery of primary care services. While these services do not have an accountability relationship with the LHIN, understanding and partnering with them is crucial to improving health outcomes, client experience and health system sustainability.

Population Profile

Source: Environmental Scan – Integrated Health Service Plan

The South West LHIN is home to 965,063 people; 7.2% of the population of Ontario. London is the largest urban centre in the South West LHIN with a population of 386,220, home to approximately 40% of residents. Almost 30% of the South West LHIN population live in a rural area and just over 30% live in small or medium communities.

Population projections for the South West LHIN suggest that population growth will be slower than Ontario as a whole. By 2016, the LHIN's population will have grown by about 2.2%, compared to 3.9% for the province overall; by 2021 the population is projected to increase by 5.6% (compared to a projected increase of 9.7% for Ontario overall).

In 2006, 14.6% of the LHIN's population was aged 65 years or over. By 2016 seniors will account for 18% of the LHIN's population; by 2021 it will be 20.7%. South West LHIN's population is aging slightly faster than the province as a whole.

In 2011, just over 85% of the LHIN's population reported English as their mother tongue. While 14.8% of the South West LHIN's population were immigrants in 2011, fewer than 2% were recent immigrants (arriving in Canada between 2006 and 2011). According to 2011 census data, Francophones account for 1.3% and Aboriginals 1.4% of the South West LHIN population. We know that immigrant, Francophone and aboriginal communities can experience difficulty accessing health care services due to cultural and language barriers.

Socioeconomic Characteristics of the South West LHIN Population

Overall, the LHIN's population is lower than the Ontario average on a number of measures including unemployment rate, education and percentage of low-income residents.

	South West	Ontario
Unemployment Rate 2011 (age 15+)	7.6%	7.8%
Education:		
Without certificate/degree/diploma	12.6%	10.2%
Completed post-secondary education	61.3%	67.2%
Living in low-income	11.7%	14.5%

General Health

Three out of five South West LHIN residents say they have *very good* or *excellent* health, and three out of four reported *very good* or *excellent* mental health. 37% of those aged 75+ still report very good/excellent health. Approximately 15% of LHIN residents say they usually experience moderate or severe pain/discomfort, and 27% say they experience activity limitations because of long-term physical or mental health problems[1].

The majority, 92%, of LHIN residents report having a regular medical doctor (similar to the provincial average).

[1] Statistics Canada, Canadian Community Health Survey 2012

Risk Factors

Approximately 22% of South West LHIN residents are smokers and 61% were regular drinkers in the last 12 months (slightly higher than provincial rates). 47% of LHIN residents are overweight or obese. Among LHIN residents aged 65-74, 63% are overweight or obese. 46% of LHIN residents are physically inactive and 61% report inadequate consumption of fruits and vegetables (consuming fewer than 5 servings daily).

Life Expectancy and Leading Causes of Death

South West LHIN residents have a slightly lower life expectancy (at birth and at age 65) compared to Ontario overall. Ischemic heart disease, lung cancer, cerebrovascular disease (stroke), breast cancer, and cancer of lymph/blood are leading causes of death.

Chronic Disease

Approximately 38% of South West residents (age 12+) have a chronic condition and 16% have multiple conditions. The prevalence of multiple chronic conditions increases dramatically with age; 35% of LHIN residents age 65-74 and 61% of those aged 75+ have two or more chronic conditions. Chronic conditions account for six out of 10 deaths, one out of four acute hospital discharges, and one out of four acute hospital days for LHIN residents. The prevalence of most chronic conditions in the South West is similar to provincial rates as described in the chart below, however mortality and hospitalization rates for all these conditions, except asthma, are higher than provincial rates.

Condition	South West LHIN	Ontario
Prevalence (2012), rate per 100, age 12+		
Arthritis	18.0	15.9
Asthma	8.2	8.0
Cancer	2.6	2.4
COPD	3.8	2.7
Diabetes	6.5	6.6
High blood pressure	17.8	16.9
Heart disease	5.3	4.9
Suffer from effects of stroke	1.2	1.2
Have a chronic condition	37.9	36.8
Have multiple chronic conditions[1]	16.1	14.4

Primary Care

There are over 750 primary care physicians and 559 of them are part of the approximately 70 primary care groups (e.g. family health teams, family health organizations, etc.) in the South West LHIN. Two key provincial programs are improving access: Primary Care Enrollment Model (PEM) and Health Care Connect (HCC) Program.

PEMs are funding and compensations models of care that focus on the comprehensive care needs of the patient, not the number of services performed by a physician. In most models, patients have access to all primary care members in the enrolling group, after hour clinics and/or Telephone Health Advisory Service. Almost 736,000 South West LHIN residents (78% of eligible residents) are enrolled with a PEM.

The HCC Program, a service that allows people to find a family physician, began in February 2009. Between February 2009 and February 2014, 33,062 LHIN residents have registered with the program and 87.6% of them have been referred to a family health service provider.

Health Human Resources Profile

The delivery of health services is dependent upon regulated and non-regulated health human resources across the LHIN. Regulated health care professionals include disciplines such as physicians, nurses, occupational therapists, physiotherapists, speech language therapy, midwives, chiropodists, pharmacists, audiologists, dieticians, massage therapists, psychologists and respiratory therapists. Non-regulated resources such as personal support workers, acupuncturists, naturopaths and chiropractors also play a critical role in the delivery of health services.

Physicians

From 2006 to 2012, the total number of physicians in South West LHIN increased by 26.5% reaching a total of 2,159 from 1,706. The number of physician to population rate in South West increased from 182.0 physicians per 100,000 population to 204.4 from 2006 to 2012. The ratio of family physicians in the South West LHIN went from 78.7 per 100,000 population in 2006 to 88.9 in 2012, but there are slightly more specialists per 100,000 population[2].

Nurses

From 2006 to 2013, the total number of nurses in South West increased by 21.6% reaching a total of 13,691 from 11,260 while the nurse to population rate increased from 1,201.3 nurses per 100,000 population to 1,418.7. Compared to the province, South West had higher RNs, RPNs and NPs rates per 100,000 population in 2013. The number of NPs in South West increased by 314% between 2006 (50) and 2013 (207).

[2] IntelliHEALTH Ontario and Ontario Physician Human Resources Data Centre

Community Engagement

In 2013-14, our communication and community engagement plan focused on:

1) Employing a variety of strategies to inform, educate, consult, evolve, collaborate and/or empower stakeholders

2) Making engagements as valuable as possible for participants and the LHIN by assessing, evolving and testing engagement approaches, leveraging all touch points and boosting participation.

Throughout 2013-14, we strived to facilitate transparency and build relationships with our health care providers, partners and the public in order to work towards a more integrated health system. A broad and inclusive approach to engagement with input from multiple stakeholder groups and communities is crucial to building a health system that balances quality, access and sustainability.

The Communications and Community Engagement Plan, as well as the directions of the 2013-2016 Integrated Health Service Plan and the Annual Business Plan, guided our engagement approach. This past year, the South West LHIN conducted a broad range of engagement activities that included:

- Regularly scheduled advisory committee meetings
- Regular meetings with Area Provider Tables
- Sector and network meetings
- Project and program-specific meetings
- Board-to-Board engagement sessions
- Community information sessions
- Governance education and dialogue sessions
- The Quality Symposium
- Health Links Patient Engagement Forum
- Physician Engagement in Partnership with the Ontario Medical Association

Stakeholders involved in these engagements included individuals, communities, political entities or organizations that have a vested interest in the South West LHIN.

Ongoing Engagement

Governance

Board-to-Board engagements are designed to provide a forum for board members from various health care organizations to meet new partners, share experiences and concerns and take cross-sector learning back to their own organizations. Board members from the South West LHIN help to facilitate discussions on the challenges they are facing, explore possible opportunities for collaboration and provide opportunities for cross-sector networking. These engagements were held in May, September and November 2013 and January and March 2014 at locations throughout our geography.

In addition to these engagements, a series of engagement sessions were held that focused on the Integrated Health Service Plan 2013-16. These Board-to-Board sessions attracted more than 230 attendees to learn how to better align their organization's strategic plans to the South West LHIN's plan for the health system. Overall, 88% of respondents remarked that they were very satisfied or fairly satisfied with the sessions.

Board to Board IHSP Information Sessions		
Location	**Date**	**Attendance**
Owen Sound	Sept. 24, 2013	38 attendees
Elgin	Oct. 02, 2013	22 attendees
Huron-Perth	Oct. 08, 2013	50 attendees
Oxford/Norfolk	Oct. 21, 2013	41 attendees
London & Middlesex	Oct. 24, 2013	45 attendees
London & Middlesex	Nov. 07 2013	34 attendees

Community Information Sessions

Community information sessions are designed to inform the community about local health services and to provide an opportunity to engage with the LHIN and health service providers. The sessions are held on a bi-monthly basis at locations across the LHIN's geography after our Board meetings to allow Board members to be in attendance.

Over 100 community members attended the five information sessions. Guests included: health service providers who presented on topics of importance in the community, health care volunteers, members of the public and health care organization board members. The focus of the information sessions differed by region, with topics such as "Improving Care for Older Adults" and "Working Together to Improve Health Care Services." In all, 88% of attendees felt that the sessions had been good or excellent and 95% of respondents felt that they had learned something new and their time had been well-spent.

Board to Board and Community Information Sessions		
Location	**Date**	**Attendance**
Markdale	May 22, 2013	26 attendees
Lion's Head	September 25, 2013	26 attendees
Tillsonburg	November 27, 2013	18 attendees
Goderich	January 21, 2014	25 attendees
London	March 18, 2014	35 attendees

3rd Annual Quality Symposium

On June 6, 2013 the South West LHIN held its 3rd Annual Quality Symposium: *Living Healthy, Independently and Safely at Home.* This one-day event brought together 425 health service providers and partners from across the South West LHIN and surrounding areas. The Quality Symposium had presentations designed to reflect on the four strategic directions of the 2013-2016 Integrated Health Service Plan:

1) Improve access to family health care
2) Improve coordination and transitions of care for those most dependent on health services
3) Drive safety through evidence-based practice
4) Increase the value of our health care system for the people we serve.

Keynote Speakers were:
Saad Rafi, Deputy Minister, Ministry of Health and Long-Term Care spoke on The Value of Living Healthy, Independently and Safely at Home,

Steve Paikin, Host of TVO's *The Agenda* moderated a panel discussion on "Improving Patient/Client Experience" that featured Paul

Collins, Freda Fregassi, Mary Ellen Gustafson, and Sue McCutcheon,

Dr. Rick Glazier, Senior Scientist and Primary Care Program Leader, Institute for Clinical Evaluative Sciences (ICES) spoke on *Strategic Direction #1: Improving Access to Family Health Care,*

Dr. Rob Annis, Mary Atkinson and Kelly Gillis spoke on the creation of the Huron Perth Health Link as an example of *Strategic Direction #2: Improving Coordination and Transitions of Care for Those Most Dependent on Health Services,*

Sandra Coleman, Dr. Hazel Lynn and Maureen Solecki spoke in the Grey Bruce Falls Prevention initiative as an example of *Strategic Direction #3: Driving Safety through Evidence-Based Practice,*

Ted Ball, Transformation Coach, Quantum Transformation Technologies spoke on *Strategic Direction #4: Increasing the Value of Our Health Care System for the People we Serve.*

Overall, we received positive feedback from those who attended. 42% of respondents indicated that it was their first Quality Symposium and 85% of respondents indicated that they were fairly satisfied or satisfied with the event.

Targeted Engagements

Physician Engagement Sessions		
Location	**Date**	**Attendance**
Mitchell	May 14, 2013	35 Attendees.
London	May 15, 2013	74 Attendees.
Owen Sound	May 29, 2013	44 Attendees.
St. Thomas (Elgin)	October 9, 2013	21 Attendees.
Ingersoll (Oxford)	November 19, 2013	23 Attendees.

Physician Engagements

To support Health Links implementation in the South West LHIN, four Health Links Physicians. Engagement sessions were held throughout 2013. These engagements were designed to inform attendees by providing them with a clear description of the Health Links initiative.

The day helped identify how Health Links will support a more coordinated approach to care in the region. The engagement sessions offered an opportunity for physicians to provide input and advice on their role in Health Links, and where they see Health Links will be able to support their work in caring for individuals with high needs.

In London, the engagement session was also used as an opportunity to identify members for the London Middlesex Primary Care Network. Physicians were concerned about the Health Link initiative getting physicians involved locally, and sought to build collaborative solutions to these challenges. Overall, 60% of respondents to a voluntary feedback survey indicated that they were satisfied or very satisfied with the event.

Long-Term Care Home Network Forum

The Long-Term Care Home Network Council hosted a Forum on May 30, 2013 in Stratford with the LHIN's support. The 130 attendees had an opportunity to share success stories and engage with system partners such as the LHIN, CCAC and Ministry of Health and Long-Term Care. The Forum also created an arena for sharing of best practices. The event enabled relationship building among organizations, to help ensure two-way communication between the Long-Term Care sector and other system partners.

2013-14 Priorities for Investment Plan Development Phase

Each year, the South West LHIN executes a Priorities for Investment Plan (PFI) to invest the discretionary funding allocations received from the Ministry of Health and Long-Term Care. In 2013, the LHIN used the process to manage and coordinate the allocation of several sources of

funds with the ultimate goal of ensuring maximum impact and coordination of services and resources. From July to August of 2013, in order to communicate the PFI plan developments the South West LHIN held meetings with each community sector, meetings with health service providers involved in proposed programs and projects, meetings with Health System Leadership Council, a meeting of the CEO Leadership Forum (Hospital/CCAC/LHIN) and two open conference calls for all health service providers.

Governance Education & Dialogue Sessions

To help ensure the transparent, efficient functioning of health service organizations in the region, the South West LHIN held three governance education and dialogue workshops in Stratford, Owen Sound and London. These sessions, which had a combined attendance of nearly 150, were designed to build better relationships, trust and mutual confidence between the members of governing bodies, and to reinforce the necessity of promoting quality in the organization from the top down. Overall, 92% of attendees indicated that they were fairly to extremely satisfied with the governance session, with: 83% remarking that they had a better understanding of their roles and responsibilities as a governor, 86% having a better understanding of their role as a governor in promoting quality, 90% reporting that they had learned something new and 90% that their time was well-spent at the workshops.

Health Links Patient Engagement Forum

In February of 2014, the Health Links Patient Engagement Forum gathered representatives from the six Health Link geographic areas in the south west area to discuss efficient patient engagement with Health Links. Over 50 stakeholders from partnering health service organizations attended to consult with patients about their health care experiences. Patients had an opportunity to communicate their desire to be integrated equally as a part of their health care team. The Patient Engagement Forum offered a chance for reciprocal communication and patient empowerment for the Health Links initiative.

Aboriginal Community Engagement

Across the LHINs, meaningful Aboriginal community engagement is critical to understanding and responding to the health needs of diverse Aboriginal peoples. By working in partnership with Aboriginal communities and involving Aboriginal people in the planning process, we are able to enhance the quality of care and patient experience for those most vulnerable and in need of health care services.

The South West LHIN engages the Aboriginal community formally through the South West LHIN Aboriginal Health Committee, comprised of Aboriginal representatives from First Nations Communities and Aboriginal organizations and health service providers located within the LHIN's area. The Committee advises the LHIN directly on Aboriginal health issues, integration and partnership opportunities. The committee also provides oversight into key Aboriginal initiatives, such as the Aboriginal Aging at Home and Mental Health and Addictions Initiative.

Here are some of the key engagements of aboriginal communities for 2013-2014:

<u>South West Aboriginal Health Committee</u>
Host ongoing bi-monthly meetings and quarterly face-to-face meetings at the South West LHIN.

<u>Diabetes – Transition of Diabetes Coordination Centre</u>
Engaged and informed key Aboriginal stakeholders on this transition by hosting a series of meetings with Aboriginal stakeholders including the Aboriginal DEP (Diabetes Education Program) team in London at the Southwestern Ontario Aboriginal Health Access Centre, Oneida Nation, Kiikeewanniikaan Healing Lodge and DEP team at Owen Sound hospital.

Physiotherapy Reform – seniors exercise and falls prevention
Engaged all key Aboriginal/First Nation Home and Community Care Coordinators and Friendship Centre Life Long Care Coordinators (2 meetings via teleconference).

Palliative Care Network
Worked to identify an Aboriginal community representative to sit on this Network (via Aboriginal Health Committee).

South West Renal Network
Worked to identify an Aboriginal community representative to sit on this Network.

CCAC and Aboriginal Home and Community Care
Engaged Aboriginal/First Nation Home and Community Care Coordinators and Friendship Centre Life Long Care Coordinators to scope and identify system wide issue; continue to host and facilitate forum for discussion with the goal to enhance patient experience and quality of care.

Cancer Care Ontario - South West Regional program

To identify a regional Aboriginal Cancer Care Lead and to provide guidance around regional Aboriginal/First Nations Inuit and Metis engagement.

Aboriginal Mental Health and Addictions – Community Capacity follow up
Reported back to the Aboriginal Community to follow-up from the Mental Health and Addictions Community Capacity report (2011) and Action Plan (2012-13).

Francophone Community Engagement

The Francophone community and stakeholders have been engaged in many different ways through the French Language Services (FLS) Coordinator. The following key engagements took place to ensure that health care planning for the Francophone community is robust and results in the needed service being developed:

1. Participation by the FLS Coordinator in many Francophone social and community events such as program launches, Franco-Ontarian flag raising ceremonies, Francophone Community Centre events, Francophone association of London events and the French Language Health Planning Entity Annual General Meeting.
2. Partnerships with Francophone stakeholders to organize a networking event "Meet the French Community of London" for health service providers and the Francophone community with the support and participation to the Ministry of Children and Youth Services on "active offer" of French language services.
3. The South West LHIN FLS Coordinator is also an active member of the *Table de concertation* francophone de London and co-chair of the "Francophone Health Sub-Committee" that facilitates different community engagement sessions one of which coordinated the validation of the French language section of the southwesthealthline.ca. As well, a focus group worked to complete a Health Equity Impact Assessment for Mental Health and Addiction services.
4. The French Language Health Planning Entity and the LHIN collaborate regularly through meetings of the Liaison Committee and the development of a joint action plan. Regular updates with the French Language Health Planning Entity for work on issues or projects as they relate to Francophone populations such as a study on services needed for Francophone seniors, development of a joint presentation on services available to seniors at the South West CCAC, distribution of the French Language Services Toolkit to appropriate health service providers and a Francophone health survey.

5. In the mental health and addictions sector, organizations worked with francophone clients to get their feedback on a Tele-psychiatry project from the Waterloo Wellington LHIN region that is being implemented in the South West LHIN. The announcement event for the French language mental health navigator is planned for early April in 2014-15.

Community Engagement - Stakeholder Audiences	
Aboriginal Steering Committee	End of Life Network
Access to Care Core Group	French Language Health Services Advisory Council
Area Provider Table – Elgin	French Language Planning entity Board of Directors
Area Provider Table – Grey Integrated Health Coalition	Health System Leadership Council
Area Provider Table – Huron Perth Providers Council	Hospital/CCAC/LHIN CEO Leadership Forum
Area Provider Table - London	Long-Term Care Homes Network Council
Area Provider Table - Middlesex	Long-Term Care Homes
Area Provider Table - Oxford	Ontario Community Support Assoc District Meeting
Board to Board Reference Group	Partnering for Quality
Chronic Disease Prevention & Management Network	Primary Care Network
Community Health Centres	Quality Advisory Group
Critical Care Network	South West Addiction and Mental Health Coalition

Integrated Health Service Plan 2013-2016

Living Healthy, Independently and Safely at Home

Home is a word with numerous connotations: house, family, community, comfort, care. It is not just where you live it is a part of you. Health enables people to be where they want to be, at home. Our Integrated Health Service Plan (IHSP) for 2013-2016 outlines strategies and objectives to support people to *live healthy, independently and safely at home.*

The health system, like a home, requires continuous maintenance, improvement and strategic investment. Together, the South West LHIN, health service providers and partners form the foundation of the health system and are tasked with increasing value through transformation, sustainability and the collaboration necessary to better meet the needs of our communities.

To help us get there we have a Blueprint – our Health System Design Blueprint: Vision 2022, our long-term vision for the health system. We also now have our third IHSP, aligned with the Blueprint and building on the accomplishments of the previous two IHSPs, to guide us through the next three years.

IHSP 2013-2016 is a call-to-action for health service providers and their boards as it outlines numerous areas where collaboration among primary care, community-based care, long-term care and hospitals will be essential to ensure high quality, sustainable health system. Progress will be measured in many ways; big and small, qualitative and quantitative.

The IHSP sets three goals:

- Improve population health and wellness
- Improve person experience with the health system
- Improve sustainability of our health system

And, defines four strategic directions to guide the work in reaching our goals.

IHSP 2013-2015 Strategic Directions

- Strategic Direction #1 - Improve Access to Family Health Care
- Strategic Direction #2 - Improve Coordination and Transitions of Care for Those Most Dependent on Health Services
- Strategic Direction #3 - Drive Safety through Evidence-Based Practice
- Strategic Direction #4 - Increase the Value of Our Health Care System for the People We Serve

To achieve the four Strategic Directions, there are 16 Program Areas. Each of the Program Areas has numerous Initiatives – 91 Initiatives in total – that will be developed and implemented in collaboration with health service providers over the next three years (2013-2016). Many of the Initiatives impact more than one Strategic Direction. There are three Key Drivers that will enable achievement of the strategic directions and initiatives.

IHSP 2013-2016 Key Drivers

- Key Driver #1 - Technology to Connect and Communicate
- Key Driver #2 - Quality and Value
- Key Driver #3 - Connecting and Empowering People

The collective impact of the strategic directions, key drivers and initiatives drive to three big dot outcomes. The 'big dots' are comprised of a number of indicators used to measure different quality outcomes and reflect the core issues that are most vital to our broader strategic objectives. The big dot outcomes will show more people spending more days '*living healthy, independently and safely at home*'.

IHSP 2013-2016 Big Dot Outcomes

- Increasing the availability of family health care
- Increasing availability and access to community supports for people
- Reducing emergency room visits and hospital readmissions

Integration Activities

The following service integrations were initiated and completed in 2013-14:

The South West LHIN Board of Directors made the following integration decisions in 2013-2014 as required under the *Local Health System Integration Act.*

Hanover Day Programs

The Medical Day Hospital Program at the Hanover and District Hospital has provided Active Rehabilitation and Maintenance Therapy to clients three days per week for many years. Home and Community Support Services has been providing adult day services to clients three days per week at the Hanover hospital. Participation House has provided assistance to clients who require personal care services through its Attendant Outreach Service primarily in people's homes and through a bathing program offered in Hanover.

Due to a number of internal pressures, the Hanover and District Hospital and Home and Community Support Services had both identified a need to reconsider how services were being delivered to ensure the right service, by the right provider at the right time in the Hanover community. As conversations continued, Participation Lodge and the South West Community Care Access Centre became involved in the discussions to determine what changes were required to ensure these community services could continue.

On May 22, 2013 the South West LHIN Board voted: "THAT the South West Local Health Integration Network Board of Directors does not wish to issue an integration decision regarding the proposed Integration or Hanover Area Day Programs as proposed in the Notice of Integration submitted to the South West LHIN on March 28, 2013 by Hanover and District Hospital, Home & Community Support Services of Grey-Bruce, Participation Lodge – Grey Bruce, and the South West Community Care Access Centre."

Proposed Benefits of the integration include:

- Ensuring the future sustainability of these programs
- Better coordination of services among providers
- Better scheduling of programs to enhance opportunities for participation
- Expansion of Adult Day Programs to five days a week helping alleviate wait-list pressures

St. Thomas Elgin General Hospital (STEGH) Ultrasound Services

Elgin Ultrasound Service Inc. is a private company that has been operating as a third party provider and has been maintained as an Independent Health Facility (IHF) at STEGH for over 30 years. On January 23, 2013, Elgin Ultrasound Service Inc. provided STEGH the required 90-day notice to terminate the provision of ultrasound services to STEGH. At that time, STEGH decided to integrate the Diagnostic Ultrasound services provided through the IHF into its Diagnostic Imaging Department.

On May 22, 2013, the South West LHIN voted: "THAT the South West Local Health Integration Network (LHIN) Board of Directors does not wish

to issue an integration decision regarding the integration outlined in the Notice of Integration submitted to the South West LHIN on April 12, 2013 by St. Thomas Elgin General Hospital."

Proposed benefits of the integration include:

- Continuation of ultrasound services at St. Thomas Elgin General Hospital
- Long-term sustainability of the service under hospital administration and leadership

Transitional Employment Program

As part of the ongoing system realignment and strengthening of mental health services in the South West LHIN, St. Joseph's Health Care works with community mental health care organizations to enhance current services and establish new programs and services governed by community agencies. The planning is aligned with recommendations by the Health Services Restructuring Commission, the Southwest Mental Health Implementation Task Team and in the South West LHIN Mental Health Community Capacity report. A key area of planning has been ongoing related to the transition of the vocational support programs provided by Regional Mental Health Care in St. Thomas (Elgin County) and London. The proposed integration that is the focus of this report is in response to the imminent closure of the Alternatives to Competitive Employment (ACE) Program in St. Thomas-Elgin. This resulted in several programs being shifted among providers in the South West LHIN requiring board approval.

On May 22, 2013 the South West LHIN Board voted: "THAT the South West Local Health Integration Network (LHIN) Board of Directors does not wish to issue an integration decision regarding the Transitional Employment Program integration proposed by Canadian Mental Health Association (CMHA) Elgin in partnership with Goodwill Industries and Habitat for Humanity in the May 13, 2013 submission to the South West LHIN."

Proposed benefits of the integration include:

- To re-position institution based employment programs to a community setting
- To scale up a sustainable Transitional Employment Program leveraging Goodwill's business platforms
- Within the new program, CMHA Elgin will expand life skills and vocational programming that is currently operated through activity centres in the St. Thomas area
- Clients will have greater opportunity to participate to the fullest of their capabilities

Huron County Obstetrics Program

Since July 2012, the Clinton Public Hospital has had to suspend regular obstetrical services due to an inability to maintain physician coverage. The physicians at Clinton Public Hospital and the surrounding area informally began to refer patients in the Clinton area to Alexandra Marine and General Hospital (AMGH) in Goderich. The Huron Perth Healthcare Alliance and the Clinton Public Hospital approached AMGH to explore current and future options for the provision of Obstetric services for the people of Huron County in response to these challenges. As a result AMGH agreed to add a Huron County Maternal/ Newborn program to service the whole of Huron County, maintaining a commitment to "closer to home". The integration of services included a midwifery program that had been available at the Clinton Public Hospital.

On June 26, 2013 the South West LHIN Board voted: "THAT the South West Local Health Integration Network (LHIN) Board of Directors does not wish to issue an integration decision regarding the proposed integration of the Huron County Maternal / Newborn Program as proposed by Huron Perth Healthcare Alliance and Alexandra Marine and General Hospital in the May 15, 2013 submission to the South West LHIN."

Proposed benefits of the integration include:

- A sustainable obstetric within Huron County
- Staffing levels and facilities will be more fully utilized with services concentrated in one site
- Appropriate volumes to ensure high quality obstetric services

London Crisis Services

London Middlesex Enhanced Mental Health Crisis and Case Management Service Integration submitted by Mission Services of London, SEARCH, LHSC, WOTCH, CMHA-LM and ADSTV in partnership with St. Leonard's Community Services and London Police Service (both non-LHIN funded). This initiative is considered to be an integration as it involves a partnership of two or more organizations, the majority of which are funded by the South West LHIN, working together to provide a full continuum of coordinated mental health crisis and case management service.

On July 24, 2013 the South West LHIN Board voted: "THAT the South West Local Health Integration Network (LHIN) Board of Directors does not wish to issue an integration decision regarding the proposed integration of London Middlesex Enhanced Crisis Service as proposed by Mission Services London, SEARCH Community Mental Health Services (SEARCH), London Health Sciences Centre (LHSC), WOTCH Community Mental Health Association (WOTCH), Canadian Mental Health Association London Middlesex (CMHA-LM) and Addiction Services Thames Valley (ADSTV) in the May 30, 2013 submission to the South West LHIN."
The focus of the integration is to improve the client experience, better coordinate resources, streamline access to service, reduce Emergency Department (ED) repeat visits, and provide the right care at the right time in the right place.

Proposed benefits of the Integration include:
It is expected that the co-location of London-Middlesex Enhanced Crisis Services at a site close to a London Health Sciences Centre Emergency Department will help to divert visits from the ED and re-direct residents of London-Middlesex to community based Crisis Services.

- The desired result is to ensure that consumers receive the right level of care, at the right time, in the right place to meet their needs with an overall expected outcome of increased access to Mental Health and/or Addiction Services and a reduction in reliance on hospital-based services.
- Health service providers are expected to operate a comprehensive coordinated community based crisis service, guided by the report detailing a comprehensive coordinated system for community crisis services as planned by key London-Middlesex Health Service Providers.
- Shared hiring, training, competencies, and orientation of Transitional Case Managers between Mission Services of London and WOTCH.
- Development of an agreed upon streamlined and coordinated intake process among London Health Sciences Centre ED, London Health Sciences Centre inpatient unit, WOTCH and Mission Services of London.
- Collaboration with London Police Services and St. Leonard's Community Services for those individuals who utilize the respective services.

John Gordon Home

The proposed integration submitted to the South West LHIN involves the London Regional AIDS Hospice/John Gordon Home (JGH) and the Regional HIV/AIDS Connection (RHAC). This is considered an integration because it involves the amalgamation of JGH (LHIN-funded) into the RHAC (non-LHIN funded).

On October 23, 2013 the south West LHIN Board voted: "THAT the South West Local Health Integration Network (LHIN) Board of Directors does not wish to issue an integration decision regarding the proposed integration between London Regional AIDS Hospice/John Gordon Home and Regional HIV/AIDS Connection as

proposed in the Formal Notice of Intended Voluntary Integration submitted to the South West LHIN on September 30, 2013."

Proposed benefits of the Integration include:

- Both organizations have similar mandates and service the same population
- JGH as a small organization does not have the capacity to continue to meet increasing demands (services and reporting requirements)
- The organizations agree that the community would be better served if the two organizations came together formally and ceased to compete in the recruitment of staff, volunteers, Board members, and donors
- People living with, at risk for or affected by HIV/AIDS and HCV will benefit from an enhanced continuum of care, no longer needing to navigate between two organizations to access the basket of services
- The merging of two distinct not-for-profit organizations and the combining of their fund development activities, staff and volunteer recruitment and community engagement strategies reduces duplication of effort
- Administrative efficiencies will be achieved by reducing the number of financial contracts and reporting obligations

Mental Health Amalgamation

On February 9, 2012, the Boards of the Canadian Mental Health Association London Middlesex (CMHA LM), Search Community Mental Health Services (Search) and Western Ontario Therapeutic Community Hostel (WOTCH) announced that they agreed to explore a voluntary integration between their three organizations. The three organizations agreed to proceed with this initiative following a meeting in January 2012, where the South West LHIN brought together several mental health and addictions providers from London, Middlesex, Oxford and Elgin to explore opportunities for integration. The three organizations are moving forward with an amalgamation. In an amalgamation, the assets, liabilities and all other attributes (both positive and negative) of each of the organizations are melded into one organization.

On October 23, 2013 the South West LHIN Board voted: "THAT the South West Local Health Integration Network (LHIN) Board of Directors does not wish to issue an integration decision regarding the proposed integration; Mental Health Services Amalgamation London Middlesex as proposed in the Formal Notice of Intended Voluntary Integration submitted to the South West LHIN on October 8, 2013 by the Canadian Mental Health Association London Middlesex, Western Ontario Therapeutic Community Hostel and Search Community Mental Health Services

Benefits of improved integration strategies include:

- Improved access to services
- Improved coordination of care, sharing of information and easier referrals
- Faster service for those needing service
- Better managed wait-lists and a "no wrong door approach"
- Reduced overlap of service and using staff more effectively
- Ability to share information, sharing of best practices among providers.
- The completion of amalgamation was officially announced with the new name "CMHA Middlesex" on March 07, 2014

Complex Continuing Care Bed and Rehabilitation Bed Changes

As part of the Access to Care (ATC) strategy to help people move out of acute hospitals and into other care settings as quickly, smoothly and safely as possible, the Complex Continuing Care bed and Rehabilitation beds (CCC/Rehab) initiative will ensure that these valuable services are provided consistently and equitably across the region. This was the South West LHIN's first facilitated integration.

On December 18, 2013 the South West LHIN Board voted: "That the South West Local Health Integration Network, Pursuant to Section 25(2)(a) of the Local Health Integration Act, 2006 (LHSIA), hereby issues an integration decision in support of the facilitated integration of Alexandra Hospital Ingersoll, Grey Bruce Health Services, St. Thomas Elgin General Hospital and Tillsonburg District Memorial Hospital. Through this decision, and with the prior endorsement of the affected health service providers, the following shall occur:

- St. Thomas Elgin General Hospital will:
  - Close 15 Complex Continuing Care (CCC) beds by April 30, 2014
  - Open 2 Rehabilitation beds by April 30, 2014
  - Release $252,298 in annualized base funds to the LHIN to reflect operating costs of the closed CCC beds, less the operating costs of the additional 2 Rehabilitation beds
  - Continue to implement coordinated access to CCC and Rehabilitation beds
  - Complete all actions by May 31, 2014.
- Alexandra Hospital Ingersoll will:
  - Close 5 Complex Continuing Care (CCC) beds by July 31, 2014
  - Close 4 additional CCC beds by October 31, 2014
  - Release $522,683 in annualized base funds to the LHIN on a prorated basis throughout the implementation period (July to October 2014) to reflect the operating costs of the closed.
- CCC beds in fiscal 2014/15
  - Continue to implement coordinated access to CCC beds
  - Complete all actions by November 30, 2014.
- Tillsonburg District Memorial Hospital will:
  - Close 6 Complex Continuing Care (CCC) beds by January 31, 2015.

Proposed benefits of the integration include:

- Admission to CCC/Rehab beds is based on consistent assessment processes and criteria and coordinated access through the South West CCAC
- Reduction of wait-times, improved utilization for CCC and Rehab beds, and a reduction in the number of patients designated as ALC
- A more equitable distribution of CCC and Rehab beds across the South West LHIN
- Reduction in Alternate Level of Care patients in the South West LHIN
- More efficient use of health system resources.

Update on South West LHIN Initiatives for 2013-14

Health Links

The Health Link initiative was announced by the Ministry of Health and Long Term Care (MOHLTC) in December 2012. It is a new model of care which seeks to improve patient outcomes through care coordination by all providers at the patient level. Partnering organizations include primary care, the South West CCAC, hospitals, community service providers, mental health and addictions agencies, long-term care homes and public health. The initial focus is on seniors and people with complex conditions who have frequent interactions with the health system. In the South West LHIN we have six Health Link areas identified: North Grey Bruce, South Grey Bruce, Huron Perth, London and Middlesex, Oxford and Elgin. Each Health Link is required to submit a business plan to the MOHLTC. Once approved, the Health Link will receive one time funding to implement the business plan with individualized care planning as the central outcome.

In 2013-14 the Huron Perth Health Link and the London Middlesex Health Links had their business plans approved and can now begin to pilot individual coordinated care plans for complex patients. The South West LHIN is working with the remaining Health Link partners to roll them out across the LHIN in a coordinated manner. The other four Health Links are all in various stages of preparing for the business planning phase.

In February 2014 The South West LHIN partnered with the Change Foundation to host a Patient Engagement Forum for the partner organizations of all six to help share best practices enabling the development of strong patient engagement strategies at the Health Links in the South West LHIN.

Improving Emergency Department Wait-Times

The South West LHIN worked with providers to improve hospital admission and discharge processes to reduce patient wait times and help improve overcrowding in Emergency Departments (ED). The LHIN identified the need for further improvements targeting patient flow, specifically for the length of time admitted patients spend in the emergency department before being moved to an inpatient bed. The South West LHIN has identified a 20% improvement target over the next fiscal year in this area.

ED Pay for Results program sites at London Health Sciences, St Thomas Elgin General, Grey Bruce Health Services (Owen Sound) and Woodstock General Hospital worked to implement key initiatives in that program.

Over the past couple of years, wait times for key emergency department indicators have improved, as demonstrated by LHIN ranking in the top five among the 14 Ontario LHINs. Of the 74 hospitals in the province that take part in the Ministry's Pay for Results program, three sites in the South West LHIN are top five overall performers: Grey Bruce Health Services (Owen Sound), Woodstock General Hospital and St. Thomas Elgin General Hospital. St. Thomas Elgin General Hospital had the lowest wait times of all participating sites in the province.

In an effort to continue improving patient flow, the South West LHIN will require all organizations participating in the Emergency Department Pay for Results Program to participate in the development and implementation of the following additional key deliverables for each organization:

- Discharge planning process and criteria for discharge, including implantation of estimated date of discharge and improvements to barriers to discharge

- Escalation processes to improve established targets for 'time to inpatient bed'
- CEO endorsement of the Pay for Results Action plan and reporting of key organizational scorecard measures
- Shift in organizational culture to improve admission to inpatient units.

The South West LHIN's Knowledge Transfer Initiative began at the Stratford, Tillsonburg, Strathroy and Woodstock hospital sites in 2013-14. The Knowledge Transfer Initiative will adapt and implement key strategies that St Thomas Elgin General Hospital developed to lead the province in emergency department wait-times reductions. Each participating hospital developed a targeted action plan for improvement in patient flow. In 2013-14, following the implementation of the Knowledge Transfer (KT) project, an improvement in wait-times for admitted patients, outside of the expected seasonal variations was observed.

In 2013-14 the South West LHIN Emergency Department Lead, Dr. Jon Dreyer, began working with colleagues from the Schedule 1 Mental Health facilities in the South West LHIN to improve ED mental health access and flow initiative. This will impact how Form1 mental health patients are referred to and assessed at the Schedule 1 facilities in the South West LHIN. The goal is to have all Form 1 Mental Health patients referred to a Schedule 1 facility assessed within 12 hours from the time the referral is made. A Working Group has been formed with representation from urban and rural Schedule 1 facilities to complete a current state analysis and develop additional strategies to improve the system for admission to Schedule 1 mental health facilities.

South West LHIN Strategies for the Home and Community Service Investments

In 2013-2014 South West LHIN staff worked hard in collaboration with health service providers across the LHIN to develop recommendations on how to invest the community sector funding increase. This was just over $21 million that was targeted to priority projects and programs to expand access to home care and community care.

The investments also supported programs that reduce unnecessary emergency room and hospital readmissions, including:

- Expanding Home First, which helps patients move from hospital to home faster with additional community services
- Adding more spaces at day programs that provide seniors and adults with complex needs with personal care services including medication administration, mealtime assistance and blood pressure checks.
- Increasing overnight caregiver respite support through Behavioural Support Ontario to allow four nights per month at five providers across the LHIN for the families of seniors who are living with dementia or have other behavioural challenges.

Other significant investments include:

- Expansion of palliative care services
- Expansion of eShift program
- Funding for the South West CCAC to achieve its five day wait time target
- Implementation of changes to adult day programs and exercise, physiotherapy and falls prevention programs
- Programs for people with acquired brain injury
- Programs for the medically fragile including the ventilator dependent
- Mental Health treatment workers
- Access to addictions services
- Mental health case management
- Supportive housing.

Mental and Addiction Services

London-Middlesex Mental Health Agency Amalgamation

As of February 2014, the Canadian Mental Health Association (CMHA) London-Middlesex, WOTCH Community Mental Health Services and Search Community Mental Health Services have officially amalgamated to form CMHA Middlesex.

The new agency will continue to serve clients in the same locations. Services will also be positively impacted in Exeter, Goderich and surrounding area.

The boards of CMHA London-Middlesex, WOTCH and Search began exploring a voluntary integration of their organizations in February 2012. The decision draws from recommendations in the report, "The Time is Now: A Plan for Enhancing Community Based Mental Health and Addiction Services in the South West LHIN." The South West LHIN Board of Directors passed a motion to support the amalgamation at their October, 2013 board meeting.

The benefits of amalgamation for clients include enhanced services in rural communities, improved access to a broader range of services, enhanced crisis response and counseling services, enhanced service delivery navigation, a streamlined process for the delivery of case management, screening, intake, referral and assessment, and improved client care experiences.

Enhanced Services for Residents in Crisis
In October 2012, CMHA London-Middlesex launched a Mobile Crisis Response Team to provide mobile crisis support 24 hours a day, 365 days a year. The team handles urgent calls from police, hospital, emergency departments, families and caregivers.

In 2013 alone, the London Mobile Crisis Response Team completed 478 crisis phone calls and completed 869 mobile response visits. London Police Services referred 644 cases to the Mobile Crisis Response Team in 2013, meaning more officers are available on the front lines where they are needed.

Mobile Crisis Response Teams are an important piece of the health system as they provide a quicker response to clients in crisis while using the most appropriate resources. Teams are made up of staff with specialized training, so they are best suited to assist clients in need.

In addition to the Crisis Response Team, 15 Transitional Case Managers with specialized training to serve people with specific needs related to mental health, addictions and those at risk of homelessness are now working in London to assist with connecting people with community-based supports, system navigation and follow-up after they leave hospital. This additional support is aimed at helping keep individuals out of Emergency Departments, quicker discharge from inpatient care and preventing hospital re-admissions.

Within the South West LHIN, there are also mobile crisis response teams serving residents in Grey-Bruce, Huron-Perth, Middlesex, Elgin and Oxford counties.

Mental Health Divestment
Since 2010 Mental Health Tier 2 Divestment has been rolling out in two components: the phased transfer of beds and related services from St.Joseph's Health Care London (SJHC) to four partner hospitals, and the overall reduction of 70 long-term mental health in-patient beds serving the South West LHIN geography with enhancements to community service capacity to support the needs of people in the community.

The first bed transfer took place in November 2010 when 50 long-term mental health beds and related ambulatory services were transferred to Grand River Hospital in Kitchener. The second occurred in November 2011 when 59 long-term mental health beds and related ambulatory services were transferred to Windsor Regional Hospital. The third transfer occurred in March 2013 when 14 long-term mental health beds and related ambulatory services were transferred to St. Joseph's Healthcare Hamilton. In January 2014, 15 acute mental health beds were transferred to St. Thomas Elgin General Hospital as part of the fourth phase. The fifth and final phase is scheduled for November 2014 with the opening of the 156 bed regional longer-term mental health care facility on the London Parkwood site of SJHC.

In support of the reduction of 70 longer-term mental health beds, as of April 2014, the South West LHIN Board of Directors has approved funding transfers to support the appropriate placement of 30 clients into the community, with a total funding transfer to community services totaling $2.7 million, placing more than 70 long stay clients in the community since 2011.

Coordinating Access to Mental Health Services
In London, Elgin and Oxford counties, mental health and addictions service providers are finding better ways to coordinate services to ensure individuals in the community are receiving appropriate, timely and seamless care. Providers are using common screening tools to make sure people will receive the right level of care regardless of how they entered the health system. They can also access a shared online calendar to make sure people get their appointments and assessments when and where they need it. Not only is it better for the client, it is also great for the health system by preventing duplication of services, streamlining the screening process, reducing fragmentation of service delivery and providing a shared language among multiple health service providers.

Improving Mental Health Care Services in Grey Bruce
Individuals living with serious mental illness in Grey-Bruce will benefit from a new Mental Health and Addictions Multi-Disciplinary Team. The project is being delivered in partnership with Grey Bruce Health Services and Canadian Mental Health Association Grey Bruce. The South West LHIN has provided funding for each organization to hire 5 additional full-time staff to provide intensive case management. The goal of the Multi-Disciplinary Team is to reduce current wait times, decrease the number of repeat visits to the emergency department, and facilitate discharge from hospital.

eHealth

In 2013-14 the South West LHIN continued to advance several key project with the long-term goal of enhancing the use of electronic sharing of information to improve the efficiency and sustainability of the health system as well as the quality of care and patient experience. Highlights of the work done in the last year are detailed in the following updates.

Connect South West Ontario (cSWO) The connecting South West Ontario (cSWO) is a Regional eHealth Program funded by eHealth Ontario. In the South West LHIN, London Health Sciences Centre (LHSC) is the transfer payment agency and the South West Community Care Access Centre (SW CCAC) acts as the Change Management & Adoption Delivery Partner (C&A DP) working with local health service providers to facilitate the business and technical adoption of cSWO electronic health regional Program solutions and standards into the regular delivery of care. The program involves hundreds of participating health service providers in the four Local Health Integration Networks of Erie St. Clair, South West, Waterloo Wellington and Hamilton Niagara Haldimand Brant.

cSWO's goal is to implement a regional eHealth Program that will make an individual's health information from across the continuum of care available in a timely and secure fashion at any point of care. This includes an integrated Electronic Health Record (EHR) and a Regional Clinical Viewer which supports the delivery of high-quality, safe and timely care. The Regional eHealth Program incorporates a number of related services, such as data support, adoption and change management, project management, privacy management and policy development.

cSWO's implementation and delivery is through a centralized program management approach, with London Health Sciences Centre as the delivery partner to eHealth Ontario with accountability for cSWO Program Management. Delivery partners in each participating LHIN are accountable for key components of the program, including regional and provincial solutions, change management and adoption, and sponsorship and registration.

ClinicalConnect A key component of the cSWO Program is the planning and deployment of a Regional Clinical Viewer that will enable authorized health care providers to view all of a patients' electronic health care information, regardless of where in the health care continuum it was collected, in real-time, from anywhere in southwestern Ontario. The clinical viewer being deployed as part of the cSWO Program is called ClinicalConnect.

ClinicalConnect is a secure online portal that provides authorized health care professionals with real-time access to their patients' electronic medical information (electronic health records) from local hospitals and Community Care Access Centres (CCACs). This means that care providers within a patient's circle of care can readily and securely access information about their patients, including reviewing their medications and test results. This enables care providers by providing a complete view of the patient's clinical journey through the health care system.

The Regional Clinical Viewer (ClinicalConnect) has been deployed to over 6,000 users in Waterloo Wellington and Hamilton Niagara Haldimand Brant LHINs. It has been deployed in all of the hospitals in these two LHINs as well as the HNHB Regional Cancer Program. All four South West Ontario Community Care Access Centres (CCACs) integrations are completed.

ClinicalConnect is currently being deployed in the Erie St. Clair and South West LHINs. Alexandra Marine and General Hospital, and Huron Perth Healthcare Alliance were completed on February 25, 2014, and Bluewater Health will be live on April 24th, 2014. In addition, lab requests and results from eHealth Ontario's Ontario Laboratories Information System (OLIS) will be integrated into ClinicalConnect effective April 24th, 2014. All hospitals in South West Ontario will be connected by early 2015. Clinicians in the South West will start to gain access to ClinicalConnect in 2014/15 as deployment plans are executed by the Change Management and Adoption Delivery Partner (South West CCAC).

Southwest Physician Interface to Regional EMR (SPIRE) was started in 2009 to help replace manual sending of hospital-generated reports by mail or fax to community-based physicians and nurse practitioners by creating "paperless" solution. This program was a huge success in the South West LHIN with over 500 physicians trained and signed up to use SPIRE replacing the manual processing of patient records. In 2013-14 work continued develop it as part of HRM, which will be rolled out across Ontario.

Hospital Report Manager (HRM) allows physicians in the community faster access to hospital physician notes and test results when one of their patients is treated in a hospital to ensure good follow-up care in the community. HRM build on successful work from 2012 to expand the HRM Pilot and the SPIRE Program to build a more robust and provincially scalable service. In 2013-14 the cSWO project team worked with eHealth Ontario and OntarioMD on the HRM deployment strategy for the South West LHIN.

The *eNotification* system integrates information between hospitals and CCACs. When a person registers at a hospital Emergency Department, identifying information is sent to the CCAC to determine if the person is currently a CCAC client enabling follow-up if changes need to be made to their care plan. In 2013-14 eNotification was launched at the Alexandra Hospital (Ingersoll), Tillsonburg District Memorial Hospital, Listowel Memorial Hospital, Wingham and District Hospital, St. Thomas Elgin General Hospital, South Huron Hospital Association (Exeter), Strathroy Middlesex General Hospital, Four Counties Health Services (Newbury), Woodstock General Hospital, and St. Joseph's Urgent Care (London).

The Integrated Assessment Record (IAR) allows users to view a client's Information to better plan and deliver services to that client. The IAR also

allows assessment information to move with a client from one health service provider to another. Long-Term Care Homes and Inpatient Mental Health facilities worked towards completing their implementations in 2013-14.

The Ontario Laboratory Information System (OLIS) is a province-wide initiative led by eHealth Ontario to develop a secure repository of laboratory results sourced from public hospitals and community labs so care providers can get timely access to test results. In 2013-14 all hospitals in Grey Bruce and the London area were actively engaged in sending data to OLIS.

Resource Matching & Referral is a new health care referral process to improve how information moves through the system. RM&R will help ensure all individuals have fast, equitable access to safe and high quality services by making sure their information is available to their providers. RM&R will also identify people who are waiting too long, or unnecessarily, in a hospital bed and help transition them to another setting to continue their receiving care. In 2013-14 there was continuous engagement of and commitment from our HSPs to work together to arrive at common referral standards and standardized referral data. Various provincial expert bodies were engaged to ensure referral data elements adhere to best practice.

After an extensive evaluation phase, the in-scope referral pathways (Acute to CCAC, Acute to LTC, Acute to CCC, Acute to Rehab) have now been finalized. Over 360 Health Service Providers across the province participated in the Initial implementation phase. Findings included:

- Extensive variation in who completes and sends referrals
- No impact to patient safety/quality was noted throughout the provincial evaluation
- Overall appreciation and acknowledgement of the benefits of Provincial Referral Standards
- Education and training are paramount to ensure referrals are being completed appropriately
- Sites that used automated referrals reported system efficiencies through the use of a lean referral process.

Now that LHIN CEOs have formally approved the Provincial Referral Standards, individual LHINs are implementing the Referral Standards at all remaining HSPs within their LHIN in 2014/15.

thehealthline.ca and its local version southwesthelathline.ca put accurate information about health care and community services available throughout the province online. In 2013-14 the southwesthealthline.ca was enhanced to add french language services, Clipboard, South West Assisted Living Form, South West Adult Day Program Form, Events Re-design, CaregiverExchange.ca provincial expansion, Stroke Resource, Service Profile Updating Tool *Regional Integrated Decision Support (RIDS)* is an information tool to share information within the South West and Hamilton Niagara Haldimand Brant LHINs. It can be used to make informed, evidence-based planning decisions for residents within these areas. In 2013-14 all hospitals and the South West CCAC successfully completed the RIDS implementation and are contributing their information the new tool. The South West CCAC successfully completed the RIDS implementation. They are contributing their information and are using the new tool. South West LHIN staff also has access to RIDS for planning and data analysis purposes.

eScreener, is a five question tool administered by hospital staff when they arrive at a hospital Emergency Department. If the outcome is "positive" that means they will require service from the CCAC when they are ready for discharge. *eReferral* automatically generates a notification for the CCAC and the case worker can follow-up so the planning for services begins at admission, not when a patient is ready for discharge, speeding the transfer to a community care setting. In 2013-14 *eScreener* was linked to an *eReferral* tool and was launched at several hospitals in the South West LHIN.

eShift is an innovative program launched in 2010 where Personal Support Workers (PSWs) receive specialized training and technology tools to provide clients with better end-of-life, palliative care at home. This information is transmitted to a nurse who monitors the patients and can intervene when concerned about a change in a client's condition enabling one Nurse can remotely monitor several patients at the same time. eShift enables clients who wish to receive quality palliative care in the home and helps support caregivers LHIN activity in 2013-14 included the allocation of over $660,000 to support and expand the program through the investment of community-sector funds.

Project funding by the South West LHIN resulted in the addition of a new service, *"Healthchat.ca."* This new online tool enables multiple users to share information and collaborate. In 2013-14 HealthChat expanded to have over 50 groups using this tool in the South West LHIN and over 1,400 user accounts were created.

Surgical Waitlist Management System is being developed as an approach to "centralized" wait list management. This is a key strategy identified by the South West LHIN's Orthopaedic Steering Committee and Working Group to allow faster access to surgeries in the LHIN. With centralized wait-list management patients wait on a central list rather that a specific surgeon's list and should access services faster. In 2013-14 the South West LHIN's business case for surgical waitlist management was completed.

Update on Services for Seniors and Adults with Complex Needs

Access to Care (ATC) continues to be an important driver in supporting people, specifically seniors and adults with complex needs, in their homes for as long as possible, with community supports. To date, over 300 representing partners across the health system have participated in this initiative. Work has been divided into three distinct but inter-related streams: Home First; Complex Continuing Care and Rehabilitation; and Assisted Living, Supportive Housing, Adult Day Programs, with coordinated activities to ensure care is provided in the right place at the right time.

Home First is a philosophical shift where everyone works together to discharge patients home from hospital with the appropriate community supports. As of March 31, 2014, this approach to care has been implemented in all South West hospitals. Investments have been made to programs to support higher needs patients/clients in their homes. Work is well underway to sustain the Home First philosophy in the South West. The ATC Lead in partnership with the South West LHIN and the CNE (Chief Nursing Executives) are in the process of developing a "Discharge Planning Toolkit" for all hospitals in the South West LHIN with the Home First philosophy embedded throughout the document.

The purpose of *the Complex Continuing Care and Rehabilitation* stream of work is to move towards equitable access to Complex Continuing Care (CCC) and Rehabilitation services throughout the South West. As a result of a facilitated integration process, the number and location of CCC and rehabilitation beds in St. Thomas, Tillsonburg, Ingersoll and Grey Bruce are changing. There are currently no CCC beds in Grey and Bruce counties and once changes are implemented there will be ten new CCC beds opening in Wiarton, starting in the fall of 2014.

Assisted Living, Supportive Housing, Adult Day Programs work has ensured the most appropriate and equitable access for clients to assist and support them to stay in their own homes. Standard processes have been developed to enable equitable access for all people in the South West and resources have been shifted to address geographic gaps in services. Through redesigns of Adult Day Programs, the development of a standard service delivery model, client fees and funding has been completed. The implementation of standard eligibility criteria has meant 48 out of 472 people

have been transitioned from Assisted Living and Supportive Housing to care that is better suited to their needs.

Coordinated Access is a collaborative admission process related to accessing long-term care, assisted living, supportive housing, adult day programs, complex continuing care and inpatient rehabilitation. This newly developed process, coordinated through the Community Care Access Centre (CCAC), ensures that clients are able to access multiple services, specific to their needs, through one source. This process has made it possible for partners to electronically compile data and report statistics to identify quality improvement opportunities.

Diabetes Program Update

In 2013-14 the Diabetes Education Programs (DEPs) began a final review of the Policies and Procedures Manual and Planning Submission templates. Diabetes Leads completed planning to engage with their Chronic Disease Prevention and Management Community of Practices to discuss the Manual and Template changes. Additionally, planning was completed for DEP staff to attend one of the two Webinars to be offered in April 2014 to highlight coming changes.

SOUTH WEST LHIN PERFORMANCE INDICATORS
2013/14 ANNUAL REPORT
May 12, 2014 Release

PI No.	Performance Indicator	LHIN 2013/14 Starting Point	LHIN 2013/14 Performance Target	Most Recent Quarter 2013/14 LHIN Performance	FY 2013/14 LHIN Annual Result
1: Access to healthcare services					
1	90th percentile ER length of stay for admitted patients	23.80	23.50	26.07	23.23
2	90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients	6.50	6.50	6.52	6.45
3	90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	3.77	3.90	3.68	3.67
4	Percent of priority IV cases completed within access target (84 days) for cancer surgery	91.00%	90.00%	92.83%	89.84%
5	Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	99.60%	90.00%	100.00%	99.00%
6	Percent of priority IV cases completed within access target (182 days) for cataract surgery	97.00%	90.00%	87.47%	90.68%
7	Percent of priority IV cases completed within access target (182 days) for hip replacement	89.00%	90.00%	80.65%	86.00%
8	Percent of priority IV cases completed within access target (182 days) for knee replacement	83.00%	90.00%	72.89%	75.62%
9	Percent of priority IV cases completed within access target (28 days) for MRI scans	45.00%	60.00%	32.14%	34.19%
10	Percent of priority IV cases completed within access target (28 days) for CT scans	90.00%	90.00%	77.28%	81.08%
2: Integration and coordination of care					
11	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	10.51%	9.46%	10.44%	10.45%
12	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	26.00	24.00	29.00	30.00
3: Quality and improved health outcomes					
13	Readmission within 30 Days for Selected CMGs**	16.81%	15.10%	17.31%	17.33%
14	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	15.60%	15.60%	13.90%	15.89%
15	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	31.80%	28.60%	26.10%	32.33%

*FY 2013/14 is based on most recent four quarters of data (Q4 2012/13 - Q3 2013/14) due to availability

**FY 2013/14 is based on most recent four quarters of data (Q3 2012/13 - Q2 2013/14) due to availability

Performance Results

The above table reports on the performance of the South West LHIN on key Ministry-LHIN Performance Agreement (MLPA) measures. In 2013-14, the South West LHIN collaborated with health service provider partners from across the health care system to: improve access to health services; improve the integration and coordination of care; and improve quality, patient/client experiences with the health care system, and health outcomes. Further, we have invested in new and enhanced services and programs in order to advance our performance objectives. Understanding impact has been enhanced through our building blocks focused on strengthened monitoring and accountability, performance management, performance and quality improvement and evaluation and capacity building.

Key measures the South West LHIN uses to monitor performance improvements are articulated in our LHIN Report on Performance Scorecard and e tool. Progress for MLPA indicators is demonstrated on the MLPA Performance Dashboard tab of the Report on Performance e tool (located at www.southwestlhin.on.ca). Overall, for the fiscal year 2013-14, the South West LHIN has met its target or showed improvements over baseline in the following six MLPA performance indicators:

- ER wait times for admitted patients
- ER wait times for non-admitted complex patients
- ER wait times for non-admitted minor uncomplicated patients
- Performing cardiac by-pass surgery within the access target (i.e. 90 days for non-urgent cases)
- Performing cataract surgery within the access target (i.e. 182 days for non-urgent cases)
- Percentage of Alternate Level of Care (ALC) Days.

Improving Emergency Department Wait Times

In general, the South West LHIN has some of the lowest emergency department wait times in the province (3rd best wait times for admitted patients, and top 5 for non-admitted patients with complex and minor uncomplicated conditions - across all LHINs). Patients and families are waiting less time for care in our area as performance has improved across all emergency department wait time indicators.

Improving Access to Surgery and Diagnostic Testing

New MLPA indicators were introduced to monitor performance related to key surgical and diagnostic wait times in 2013-14. Performance is now being monitored for the percent of non-urgent (i.e. priority IV) cases completed within access target. In 2013-14, wait times were better than the target of 90% for cardiac by-pass surgery and cataract surgery and were very close to target for the year, slipping to just below target in one quarter. Key wait time improvement strategies through Performance Management Teams, enhanced reporting and monitoring, and process improvement work are underway to both guide and drive improvement in the wait times for joint replacements, cancer surgeries, and diagnostic imaging scans.

Improving ALC

The Access to Care initiative (including Home First, Assisted Living/ Supportive Housing/ Adult Day Programs and Complex Continuing Care) has been a key component of our strategy to support people—specifically seniors and adults with complex needs—to live safely in their homes for as long as possible. Through Home First, we continue to see more people able to return to their homes following a hospital encounter and less people staying in hospital when their acute

phase is complete (i.e. as an Alternate Level of Care (ALC) patient). Almost one-third fewer patients remain in South West LHIN acute hospital beds awaiting long-term care than a year ago. Even greater gains are observed for post-acute beds comparing the current number of ALC patients to two years ago. These improvements are essential to keep hospital beds available and accessible to those patients who need hospital care and services. Reducing the number of patients waiting in hospital for long-term care is important as wait times can be several weeks or months. Improving the availability and access to other care settings—including safe care at home and in affordable assisted living facilities—will further improve the South West LHIN's ALC rate.

At the start of the 2013-14 fiscal year, the South West LHIN had the lowest MLPA ALC baseline or "starting point" from which to measure progress and it was one of only two LHINs to adopt the challenging provincial target of ALC days comprising 9.46% or less of acute hospital days. While we haven't quite reached our target, we have made further improvements over baseline and were recently ranked 3rd among all LHINs for achievements on this ALC measure.

Opportunities for Improvement

Although we have seen good performance in many areas, we still have work to do in achieving other performance objectives. For example, our wait times for joint replacement (i.e. hip and knee) surgeries, Magnetic Resonance Imaging (MRIs) and computed tomography (CT) scans have worsened in the past year. Efforts are underway to drive improvements and further analysis will identify additional needed strategies and ways to cope with increasing demand for these services.

We expect that wait times to access CCAC in-home services will rebound and be back on track following a change in programming that occurred in 2013-14. Investments in crisis services and transitional case management, collaboration, and integration among community mental health and addictions service providers are beginning to show signs of bringing emergency department re-visit rate measures more in line with targets. Spreading best hospital discharge practices and supporting and facilitating the development of Health Links across the LHIN are also expected to lead to improvements in the measure gauging readmissions to hospital within 30 days of discharge.

Year two of our three-year IHSP will bring heightened efforts and energy to drive and support performance improvement in these MLPA measures as well as in our key strategic objectives and outcomes.

Operational performance

In 2013/14, the South West LHIN operating budget was made up of two components:

$5.0 million for operations
$2.2 million for special projects

Operations

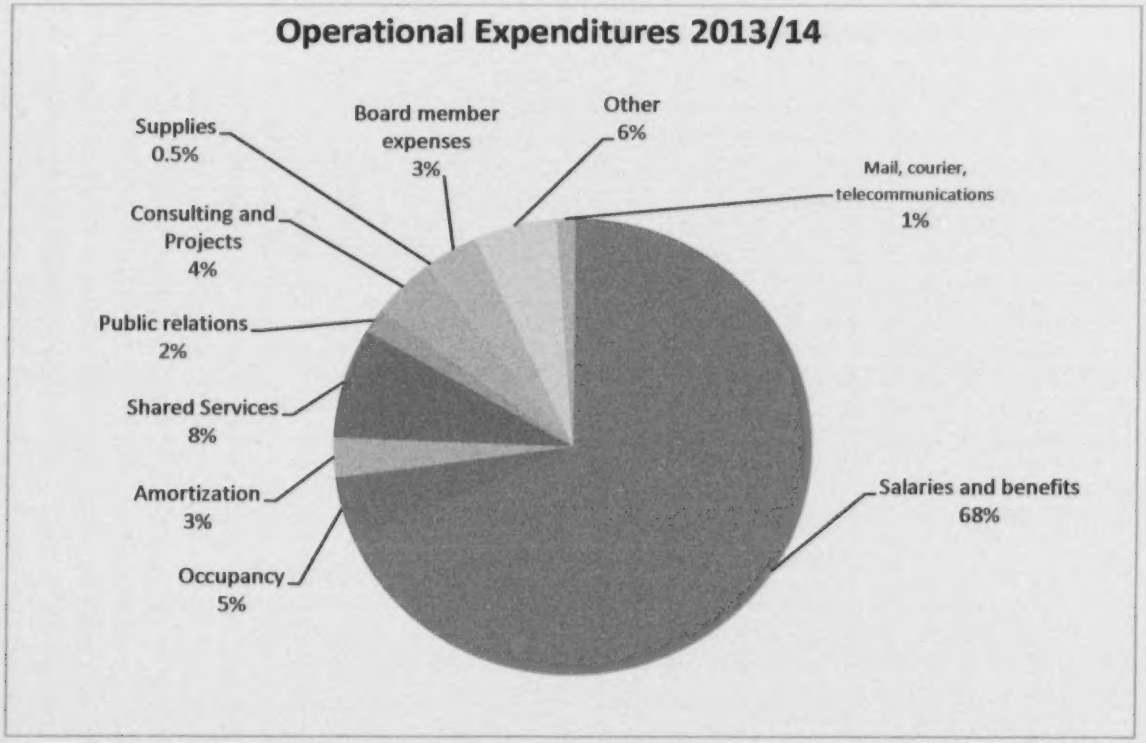
The South West LHIN ended the year with an operating surplus of $844. There were surpluses relating to the funding for other special projects. The chart below shows the 10 major categories of expenditures for the South West LHIN. Our largest expenditure is salaries and benefits with 34 full-time employees (FTEs) which included three contract staff. The LHIN also had one seconded position.

Special Projects

In addition, the LHIN hired 10 FTEs, added one secondment, and seven contract staff for specific projects. The base and one-time funding received and expenditures by the South West LHIN to undertake planning and development for special projects during the 2013/14 fiscal year were:

	Funding $	Expenditure* $
Aboriginal Planning (Base)	35,000	30,203
French Language Services (Base)	106,000	93,908
Diabetes Regional Coordination Centres (Base)	946,212	816,627
Enabling Technologies	580,000	511,019
E-Health SPIRE	187,739	187,739
Critical Care Lead	75,000	72,613
Emergency Department Lead	68,220	67,655
Primary Care Lead	75,000	72,052
ER/ALC Lead	100,000	84,386
Total	**2,173,171**	**1,936,202**

**Surpluses returned to Ministry of Health and Long-Term Care*


Operational Expenditures 2013/14
Supplies 0.5%
Board member expenses 3%
Other 6%
Mail, courier, telecommunications 1%
Consulting and Projects 4%
Public relations 2%
Shared Services 8%
Amortization 3%
Occupancy 5%
Salaries and benefits 68%

Financial statements of

South West Local Health Integration Network

March 31, 2014

South West Local Health Integration Network

March 31, 2014

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Independent Auditor's Report

To the Members of the Board of Directors of the
South West Local Health Integration Network

We have audited the accompanying financial statements of South West Local Health Integration Network, which comprise the statement of financial position as at March 31, 2014, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of South West Local Health Integration network as at March 31, 2014 and the results of its operations, changes in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 20, 2014

South West Local Health Integration Network

Statement of financial position
as at March 31, 2014

	2014	2013
	$	$
Financial assets		
Cash	**848,079**	892,912
Due from Ministry of Health and Long-Term Care ("MOHLTC") Health Service Provider ("HSP") transfer payments (Note 9)	**11,537,917**	8,505,822
Due from the LHIN Shared Services Office (Note 4)	**-**	17,190
Harmonized sales tax receivable	**59,791**	79,069
Accounts receivable	**-**	3,879
	12,445,787	9,498,872
Liabilities		
Accounts payable and accrued liabilities	**422,393**	795,784
Due to Health Service Providers ("HSPs") (Note 9)	**11,537,917**	8,505,822
Due to MOHLTC (Note 3b)	**537,813**	176,111
Due to eHealth Ontario (Note 3c)	**-**	52,319
Due to the LHIN Shared Services Office (Note 4)	**3,316**	-
Deferred capital contributions (Note 5)	**140,632**	262,387
	12,642,071	9,792,423
Net debt	**(196,284)**	(293,551)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	**55,652**	31,164
Tangible capital assets (Note 7)	**140,632**	262,387
	196,284	293,551
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

The accompanying notes to the financial statements are an integral part of these financial statements.

South West Local Health Integration Network

Statement of operations
year ended March 31, 2014

	Budget (Note 8)	2014 Actual	2013 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	**2,151,445,002**	**2,215,597,061**	2,190,349,994
Operations of LHIN	**4,895,719**	**4,909,473**	4,873,561
Aboriginal Planning (Note 10a)	**35,000**	**35,000**	35,000
French Language Services (Note 10b)	**106,000**	**106,000**	106,000
Critical Care (Note 10c)	**75,000**	**75,000**	75,000
Emergency Department ("ED") Lead (Note 10d)	**75,000**	**68,220**	75,000
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead (Note 10e)	**100,000**	**100,000**	100,000
Primary Care Lead (Note 10f)	**75,000**	**75,000**	75,000
Enabling Technologies ETI PMO (Note 10g)	**580,000**	**580,000**	578,560
Diabetes Regional Coordinating Ctr (Note 10h)	**1,200,620**	**946,212**	206,632
E-Health SPIRE & cSWO (Note 10i)	**187,739**	**187,739**	773,833
Amortization of deferred capital contributions (Note 5)	**139,890**	**139,890**	162,000
	2,158,914,970	**2,222,819,595**	2,197,410,580
Funding repayable to eHealth Ontario (Note 3a)	-	-	(34,865)
Funding repayable to the MOHLTC (Note 3a)	-	**(237,813)**	(176,111)
	2,158,914,970	**2,222,581,782**	2,197,199,604
Expenses			
Transfer payments to HSPs (Note 9)	**2,151,445,002**	**2,215,597,061**	2,190,349,994
General and administrative (Note 11)	**5,035,609**	**5,048,519**	4,981,477
Aboriginal Planning (Note 10a)	**35,000**	**30,203**	32,760
French Language Services (Note 10b)	**106,000**	**93,908**	93,198
Critical Care (Note 10c)	**75,000**	**72,613**	74,508
ED Lead (Note 10d)	**75,000**	**67,655**	73,944
ER/ALC Performance Lead (Note 10e)	**100,000**	**84,386**	98,245
Primary Care Lead (Note 10f)	**75,000**	**72,052**	74,889
Enabling Technologies (Note 10g)	**580,000**	**511,019**	512,356
Diabetes Regional Coordinating Ctr (Note 10h)	**1,200,620**	**816,627**	169,265
E-Health SPIRE & cSWO (Note 10i)	**187,739**	**187,739**	738,968
	2,158,914,970	**2,222,581,782**	2,197,199,604
Annual surplus and accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

South West Local Health Integration Network

Statement of change in net debt
year ended March 31, 2014

	2014 Actual $	2013 Actual $
Annual surplus	-	-
Change in prepaid expenses, net	**(24,488)**	7,506
Acquisition of tangible capital assets	**(18,135)**	(156,633)
Amortization of tangible capital assets	**139,890**	162,000
Decrease in net debt	**97,267**	12,873
Net debt, beginning of year	**(293,551)**	(306,424)
Net debt, end of year	**(196,284)**	(293,551)

The accompanying notes to the financial statements are an integral part of these financial statements.

South West Local Health Integration Network

Statement of cash flows
year ended March 31, 2014

	2014	2013
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**139,890**	162,000
Amortization of deferred capital contributions (Note 5)	**(139,890)**	(162,000)
Changes in non-cash operating items		
Increase in due from MOHLTC HSP transfer payments	**(3,032,095)**	(6,479,929)
Decrease (increase) in due from LHIN Shared Services Office	**17,190**	(17,190)
Decrease in accounts receivable	**3,879**	12,611
Decrease (increase) in Harmonized Sales Tax receivable	**19,278**	(33,714)
(Decrease) Increase in accounts payable and accrued liabilities	**(373,391)**	487,766
Increase in due to HSPs	**3,032,095**	6,479,929
Increase in due to MOHLTC	**361,702**	128,029
Decrease in due to eHealth Ontario	**(52,319)**	(10,472)
Increase (decrease) in due to LHIN Shared Services Office	**3,316**	(7,440)
(Increase) decrease in prepaid expenses	**(24,488)**	7,506
	(44,833)	567,096
Capital transaction		
Acquisition of tangible capital assets	**(18,135)**	(156,633)
Financing transaction		
Deferred capital contributions received (Note 5)	**18,135**	156,633
Net (decrease) increase in cash	**(44,833)**	567,096
Cash, beginning of year	**892,912**	325,816
Cash, end of year	**848,079**	892,912

The accompanying notes to the financial statements are an integral part of these financial statements.

1. Description of business

The South West Local Health Integration Network was incorporated by Letters Patent on July 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the South West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers approximately 22,000 square kilometers from Tobermory in the north to Long Point in the south. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any Ministry managed programs.

The LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario - LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The LHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. Unspent amounts are recorded as payable to the MOHLTC at period end. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital revenue and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use, during the year, amortization is provided for a full year.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimate and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC and eHealth Ontario

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to eHealth Ontario.

a) The amount repayable to the MOHLTC and eHealth Ontario related to current year activities is made up of the following components:

	Funding	Eligible expenses	2014 Funding excess	2013 Funding excess
	$	$	$	$
Transfer payments to HSPs	2,215,597,061	2,215,597,061	-	-
LHIN operations	4,909,473	4,908,629	844	54,084
Aboriginal Planning	35,000	30,203	4,797	2,240
French Language Services	106,000	93,908	12,092	12,802
Enabling Technologies	580,000	511,019	68,981	66,204
E-Health SPIRE	187,739	187,739	-	34,865
Critical Care Lead	75,000	72,613	2,387	492
ED Lead	68,220	67,655	565	1,056
Primary Care Lead	75,000	72,052	2,948	111
ER/ALC Lead	100,000	84,386	15,614	1,755
Diabetes Regional Coor. Centres	946,212	816,627	129,585	37,367
	2,222,679,705	2,222,441,892	237,813	210,976

b) The amount due to the MOHLTC at March 31 is made up as follows:

	2014	2013
	$	$
Due to MOHLTC, beginning of year	176,111	48,082
Funding repaid to MOHLTC	(176,111)	(48,082)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	237,813	176,111
Funding repayable to the MOHLTC related to current year ETI PMO Cluster activities (Note 10g)	300,000	-
Due to MOHLTC, end of year	537,813	176,111

3. Funding repayable to the MOHLTC and eHealth Ontario (continued)

c) The amount due to eHealth Ontario at March 31 is made up as follows:

	2014	2013
	$	$
Due to eHealth Ontario, beginning of year	**52,319**	62,791
Paid to eHealth Ontario during year	**(52,319)**	(45,337)
Funding repayable to the eHealth Ontario related to current year activities (Note 3a)	**-**	34,865
Due to eHealth Ontario, end of year	**-**	52,319

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year-end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC is to support the LHINs in fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system; their role as system manager; where appropriate, the consistent implementation of provincial strategy and initiatives; and the identification and dissemination of best practices. LHINC is a LHIN-led organization and accountable to the LHINs. LHINC is funded by the LHINs with support from the MOHLTC.

5. Deferred capital contributions

	2014	2013
	$	$
Balance, beginning of year	**262,387**	267,754
Capital contributions received during the year (Note 8)	**18,135**	156,633
Amortization for the year	**(139,890)**	(162,000)
Balance, end of year	**140,632**	262,387

6. Commitments

The LHIN has commitments under various operating leases extending to 2019 related to building and equipment which have standard renewal terms. Minimum lease payments due in each of the next five years are as follows:

	$
2015	294,254
2016	109,682
2017	4,789
2018	4,014
2019	191

6. Commitments (continued)

The LHIN also has funding commitments to HSPs associated with accountability agreements. Minimum commitments to HSPs, based on the current accountability agreements, are as follows:

	$
2015	2,149,388,354

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Tangible capital assets

	Cost	Accumulated amortization	2014 Net book value	2013 Net book value
	$	$	$	$
Computer equipment	212,709	170,709	42,000	52,047
Leasehold improvements	1,588,789	1,506,773	82,016	173,027
Office equipment, furniture and fixtures	218,003	201,387	16,616	37,313
	2,019,501	1,878,869	140,632	262,387

8. Budget figures

The budget was approved by the Government of Ontario. The budget figures reported in the statement of operations reflect the initial budget at April 1, 2012. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $2,215,597,061 is derived as follows:

	$
Initial budget	2,151,445,002
Adjustment due to announcements made during the year	64,152,059
Final HSP funding budget	2,215,597,061

The final LHIN budget, excluding HSP funding, of $7,082,644 is derived as follows:

	$
Initial budget	5,036,719
Additional funding received during the year	2,064,060
Amount treated as capital contributions during the year	18,135
Final LHIN operating budget	7,082,644

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,215,597,061 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2014 as follows:

	2014	2013
	$	$
Operation of hospitals	**1,551,196,371**	1,566,756,371
Grants to compensate for municipal taxation - public hospitals	**451,500**	451,500
Long term care homes	**313,729,659**	299,613,261
Community care access centres	**205,929,789**	188,487,125
Community support services	**42,588,870**	39,092,788
Assisted living services in supportive housing	**17,999,245**	17,490,024
Community health centres	**18,679,068**	16,979,597
Community mental health addictions program	**65,022,559**	61,479,328
	2,215,597,061	2,190,349,994

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2014, an amount of $11,537,917 (2013 - $8,505,822) was receivable from MOHLTC, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and are included in the table above.

10. Programs

a) *Aboriginal Planning*

The MOHLTC provided the LHIN with $35,000 (2013 - $35,000) related to aboriginal planning. The LHIN incurred operating expenses totaling $30,203 (2013 - $32,760). The LHIN has setup a payable to the MOHLTC for the remaining balance of $4,797.

Expenses incurred are by the LHIN are:

	2014	2013
	$	$
Consulting services	**20,311**	30,000
Supplies, equipment and licenses	**13**	31
Mail, courier and telecommunications	**655**	943
Other	**9,224**	1,786
	30,203	32,760

b) *French Language Services*

The MOHLTC provided the LHIN with $106,000 (2013 - $106,000) related to French Language Services funding. The LHIN incurred consulting expenses totaling $93,908 (2013 - $93,198). The LHIN has setup a payable to the MOHLTC for the remaining balance of $12,092.

c) *Critical Care Lead*

The MOHLTC provided the LHIN with $75,000 (2013 - $75,000) related to Critical Care initiatives. The LHIN incurred consulting expenses totaling $72,613 (2013 - $74,508). The LHIN has setup a payable to the MOHLTC for the remaining balance of $2,387.

10. Programs (continued)

d) ED Lead

The MOHLTC provided the LHIN with $75,000 (2013 - $75,000) related to Emergency Department initiatives. The LHIN incurred consulting expenses totaling $67,655 (2013 - $73,944). The MOHLTC collected from the LHIN, $6,780 as an in year recovery. The LHIN has setup a payable to the MOHLTC for the remaining balance of $565.

e) ER/ALC Lead

The MOHLTC provided the LHIN with $100,000 (2013 - $100,000) related to emergency room management strategy funding. The LHIN incurred consulting expenses totaling $84,386 (2013 - $98,245). The LHIN has setup a payable to the MOHLTC for the remaining balance of $15,614.

f) Primary Care Lead

The MOHLTC provided the LHIN with $75,000 (2013 - $75,000) related to Primary Care initiatives. The LHIN incurred consulting expenses totaling $72,052 (2013 - $74,889). The LHIN has setup a payable to the MOHLTC for the remaining balance of $2,948.

g) Enabling Technologies for Integration Project Management Office

Effective January 31, 2014, the LHIN entered into an agreement with Erie St. Clair, Hamilton Niagara Haldimand Brant and Waterloo Wellington (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses.

The following provides condensed financial information:

	2014		2013
	Total	LHIN's portion	LHIN's portion
	$	$	$
Revenue	2,320,000	580,000	578,560
Expenses	1,951,019	511,019	512,356
Accumulated surplus	368,981	68,981	66,204

Expenses incurred are by the LHIN are:

	2014	2013
	$	$
Salaries and benefits	360,023	445,663
Occupancy	23,877	19,664
Consulting services	100,000	-
Supplies, equipment and licenses	1,377	3,360
Travel	1,464	8,872
Mail, courier and telecommunications	2,668	7,704
Other	21,610	27,093
	511,019	512,356

10. Programs (continued)

g) Enabling Technologies for Integration Project Management Office (continued)

The MOHLTC provided the LHIN with $2,320,000 (2013 - $580,000) related to Enabling Technologies initiatives. The LHIN incurred operating expenses of $511,019 (2013 - $512,356) and capital expenses of $Nil (2013 - $1,440) have been recorded as capital assets and the related funding has been recorded as deferred capital contributions. The LHIN cash flowed $1,440,000 to the other LHINs. The LHIN has setup a payable to the MOHLTC for the remaining balance of $368,981.

h) Diabetes Regional Coordination Centres

The MOHLTC provided the LHIN with $1,200,620 (2013 - $338,228) related to Diabetes Regional Coordination Centres initiatives. The LHIN incurred operating expenses of $816,627 (2013 - $169,265) and capital expenses of $8,544 (2013 - $131,596) have been recorded as capital assets and the related funding has been recorded as deferred capital contributions. The MOHLTC collected from the LHIN, $249,863 as an in year recovery. The LHIN has setup a payable to the MOHLTC for the remaining balance of $129,585. Expenses incurred include the following:

	2014	2013
	$	$
Salaries	**742,683**	34,205
Operating expenses	**70,239**	4,792
One-time expenses	**8,250**	261,864
Total	**821,172**	300,861

i) eHealth Ontario – SPIRE & cSWO

The LHIN entered into a transfer payment agreement with eHealth Ontario providing $187,739 (2013 - $775,272) to the LHIN, related to Southwest Physicians Interface with Regional EMRs (SPIRE). The LHIN incurred operating expenses of $187,739 (2013 - $738,968) and capital expenses of $nil (2013 - $1,439) have been recorded as capital assets and the related funding has been recorded as deferred capital contributions.

Expenses incurred are by the LHIN are:

	2014	2013
	$	$
Salaries and benefits	**100,164**	417,321
Occupancy	**9,949**	19,664
Consulting services	**65,000**	244,960
Supplies, equipment and licenses	**84**	2,807
Travel	**2,034**	12,391
Mail, courier and telecommunications	**2,708**	6,758
Other	**7,800**	35,067
	187,739	738,968

11. General and administrative expenses

The statement of operations presents the expenses by function; the following classifies general and administrative expenses by object:

	2014	2013
	$	$
Salaries and benefits	**3,450,665**	3,385,331
Occupancy	**224,980**	206,682
Amortization	**139,890**	162,000
Shared services	**341,521**	341,520
LHIN Collaborative	**54,357**	47,500
Public relations	**87,185**	90,192
Consulting and Project expenses	**219,451**	178,194
Supplies	**20,983**	25,901
Board chair per diem	**44,145**	52,805
Board member per diem	**64,623**	38,490
Board member expenses	**55,832**	47,101
Mail, courier and telecommunications	**61,992**	84,711
Other	**282,895**	321,050
	5,048,519	4,981,477

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 30 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2014 was $ 330,642 (2013 - $287,905) for current service costs and is included as an expense in the statement of operations. The last actuarial valuation was completed for the plan as at December 31, 2013. As at that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favor of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s.28 of the Financial Administration Act.

14. Comparative figures

Certain comparative figures have been reclassified to conform to the current year presentation.

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